CLAIMS AUDIT GUIDELINES

INTRODUCTION

A.   <u>BACKGROUND</u>

Claims processing services are competitively procured through contractors. Each TRICARE claims processing contractor is contractually responsible for timely and accurate adjudication of all TRICARE claim types for a specific regional jurisdiction. Each Managed Care Support Services (MCSS) contractor is also responsible for reporting to TMA payment records of all claim transactions via an electronic teleprocessing network. These payment records are essential to both the accounting and statistical requirements of TMA in management of the Program and in required reports to the Department of Defense, Congress, other governmental entities and to the public.

B.   <u>PURPOSE OF THE CLAIMS AUDIT</u>

The purpose of the ongoing claims audit program of TMA is to determine the accuracy of each MCSS contractor's claims processing and payment record coding. The error findings are reported in terms of payment error rates and payment record occurrence error rates. These error rates are important indicators of each contractor's performance. The error rates are used to determine whether the contractor qualifies for monetary awards or reductions in accordance with the positive and negative provisions of the MCSS contracts annual target. The purpose of the Target Health Care cost audits is to support the accuracy of the contractor reported allowable costs. The audits serve to identify specific areas of contractual noncompliance requiring corrective action by the contractor and to determine if certain changes to operational and policy requirements have been implemented by each MCSS contractor as directed by TMA.

C.   <u>APPLICABILITY OF THE CLAIMS AUDIT GUIDELINES</u>

These procedures and guidelines are intended solely for the use of the auditors in the TMA, Claims Operations Office or the Claims Review Assistance Services contractor. They have been written solely for the purpose of facilitating the auditing of managed care MCSS contractor processed claims. They are not intended, nor should they be construed, in any way to take precedence over or contradict MCSS contractor contractual requirements or existing legislative, regulatory or policy directives relative to Chapter 55, Title 10, United States code. They are not intended to provide operational or procedural guidance to the contractor.

Any contradictions or inconsistencies between these guidelines and the directives and contractual requirements referred to above are unintentional and are to be brought to the attention of the Chief, Claims Operations Office, TMA.

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CHAPTER 1 – TED CLAIMS AUDIT PROCESS

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CHAPTER 1 – TED CLAIMS AUDIT PROCESS

A.   General

    1.   Purpose. The primary purpose of the TMA claims audit is to determine the accuracy of institutional claims payments, non-institutional claims payments, and institutional and non-institutional payment record coding. The resulting error rates are used in the evaluation of contractor performance and in the quarterly application of incentive provisions of contracts.

    2.   Scope. The audit process entails 1) the evaluation of contractor payment determinations based on the claims, attendant documentation and other source documents and files used in the adjudication process and 2) the evaluation of contractor payment record coding based on the above documentation and the contractor payment determinations. These evaluations are made by comparing the contractor's processing and coding decisions with requirements in the TRICARE Policy Manual; the TRICARE Reimbursement Manual; the TRICARE Operations Manual; the TRICARE Systems Manual; and the individual contracts.

    3.   Claim Sampling. Generally, each contract is audited on a quarterly basis. Samples of each contractor's processed claims are selected by contract from edited payment record submissions received at TMA within each calendar quarter. This sample selection process is automated and begins the sequence of auditing events.

B.   Conducting the Audit

    1.   Preparation

        a.   Prior to beginning each audit, the auditor will review the Deficiency File for the individual contract he/she is to audit to become familiar with error findings from previous audits.

        b.   The claims and corresponding TADRs are to be sequentially numbered for ease in associating these.

    2.   Use of the TED Audit Detail Report (TADR)

        a.   The primary tool during the audit is the TADR. This report is a facsimile of the payment records as reported by the MCSS contractor for those claims selected for audit. The TADR format is found in the TRICARE Systems Manual, Chapter 2, Sections 2.2. Each data field is identified by abbreviated name and labeled with an alpha-numeric code which is used for recording error conditions. The auditor records errors on this form as they are identified by highlighting or otherwise marking the error code or field. Explanations of reasons for assessing errors will also be entered on the TADR in narrative form.

Since these reports will be stored after the audit, care must be taken to maintain their legibility.

        b.   The TADR also contains provider information, procedure and diagnostic code narrative descriptions, pricing information, and zip code catchment area information based on the data submitted on the payment record

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by the contractor to facilitate recording of errors and eliminate some file look-ups.

    3.   <u>Auditing Techniques.</u> Specific error assessment and auditing guidelines are provided in Chapters 3, 4, and 5. Each auditor develops an approach to verify the accuracy of each contractors payment record coding and benefit determinations during on-the-job training and experience. Generally, the following considerations apply to every claim audited. These are not all-inclusive nor is any sequential order prescribed. Each auditor is expected to develop an approach which is most effective for timely and accurate results.

        a.   Was the claim properly executed (appropriate signatures, timely filed, valid claim form, provider participation certification)?

        b.   Is the patient eligible? Is the patient enrolled in TRICARE Prime? Is the patient and sponsor information properly coded?

        c.   Is the provider authorized? Is the provider contracted or not contracted? Is the provider information (provider number, zip code, specialty, capacity) coded correctly?

        d.   Is the diagnosis coded properly? Is it covered?

        e.   Is a preauthorization or Care Authorization/Nonavailability Statement (CA/NAS) needed? If so, is it present?

        f.   Are the service(s) and date(s) of service coded properly? Is each service a benefit? Is each service medically necessary? Was it provided at the appropriate level? Does it require medical review? If so, is documentation of the medical review determination present and correct?

        g.   Are the billed charges reported correctly? Are the allowed amounts correct? Was other health insurance or third party liability properly considered? Is the deductible properly credited? Is the patient's cost-share correct? Is the amount of payment correct? Was payment made to the correct party?

        h.   Was the payment record properly prepared? Are the data fields coded correctly?

    4.   <u>Medical Review Determinations.</u> Claims involving questionable MCSS contractor decisions regarding medical necessity and appropriateness of care issues, regardless of the dollar amounts involved, will be handled as follows if available policy guidelines are silent on the issue:

        a.   Consult with a Nurse Consultant or a registered nurse to make a determination.

        b.   Based on consultation with the above individuals, a determination regarding the contractor's decision will be made for purposes of issuing the audit report timely.

C.   <u>Post-Audit Reports</u>

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1.   Creating the Post-Audit Reports. After all claims for the audit month have been audited, the auditor enters the error findings and comments into the automated TED Record Audit System and generates the post-audit reports. The post-audit reports consist of the following:

     a.   MCSS Contractor TED Record Audit Summary Report

     b.   TED Audit Analysis of Errors Report

     c.   TED Audit Listing, Part I and II

     d.   TED Audit Error Report

2.   Verification of the Audit Reports. Since the accuracy of the quarterly claims audit reports is essential, the following steps are critical.

     a.   Auditors are to verify that the totals on the Audit Summary Report match the totals on the Claim Summary Report. Inconsistencies which the auditor is unable to resolve are to be reported to the lead or supervisor.

     b.   Auditors will also compare the data reported on the Audit Errors Report with the highlighted errors contained on the TADR.

D.   Analysis of Managed Care Support Services Contractor Errors

1.   An Analysis of Errors Summary is prepared for each audit by the auditor following the completion of the second rebuttal.

2.   Significant Audit Findings. Occurrence and payment error findings are considered significant deficiencies when they represent high volume errors, high dollar amount errors, or errors which by their nature have the potential for rarely occurring. Also significant are those findings which indicate a MCSS contractor has failed to implement or has incorrectly implemented a contractual requirement, e.g., TRICARE Policy/ Reimbursement/ Operations/ TRICARE Systems Manual changes, or which indicate other substantive processing problems, e.g., EOBs sent to minors.

3.   Monitoring Deficiencies. Prior to beginning an audit, the auditors will review each MCSS contractor's error report file for those findings to be monitored.

E.   Rebuttals of Audit Findings

1.   Time Period. Generally MCSS contractors have 45 calendar days following receipt of the audit reports to rebut the findings or notify TMA/COO or designee, that no rebuttal will be submitted.

2.   Responses to Rebuttals

     a.   Responses must be clear, concise and self-explanatory, addressing each issue raised by the MCSS contractor. In most cases, it will be necessary to reiterate the issue or question in order that those reviewing and concurring in the reply will fully understand the response. This is especially important in those cases where the auditor is sustaining the original determination or removing errors for reasons other that those cited

CLAIMS AUDIT GUIDELINES

in the MCSS contractor's rebuttal. Appropriate references, e.g., TRICARE Operations Manual or TRICARE Systems Manual are to be cited whenever possible.

       b.   Responses are to be in a format which addresses the claim number, beneficiary name, claim type, disputed errors, contractor rebuttal position, position after consideration, errors removed and errors assessed.

F.   <u>Confidentiality of Audit Documents.</u> All TRICARE claims and claim documentation used in the claims audit are subject to the provisions of the Privacy Act of 1974, HIPAA Privacy Rule of 2002, and all DoD Privacy requirements since they contain information of a personal nature on each beneficiary. Due to the confidential nature of the information, each auditor is responsible for safeguarding these documents as follows:

    1.   While auditors are away from their work area for any extended time, such as leave or after duty hours, all claims are to be placed in the file drawers.

    2.   For a brief period of absence, such as a break, lunch or meeting, all documents are to be covered or placed in such a way so that they are not visible to a casual observer.

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CHAPTER 2 - AUTOMATED AUDIT SYSTEMS

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CHAPTER 2 - AUTOMATED AUDIT SYSTEMS

A.   Introduction. This chapter describes the objectives and features of the automated TED Audit System and provides an overview of the auditor's interface with these two systems. The objectives of the TED Audit System is to facilitate and enhance the accuracy and timely completion of the audits and production of audit reports through automation of the claims audit functions.

On-line access to procedure codes, zip code tables, provider information, pricing information, deductible and catastrophic cap information.

Error collection

Production of audit reports

Audit error summary reports

B.   Scope of Automated Features.

1.   The TED Audit System interfaces with the Care Information (CI) system to make a quarterly random selection of claims. During this selection process, the system also interfaces with various files and tables to provide narrative descriptions of procedure and diagnosis codes, catchment area information based on zip codes, provider information, and pricing data.

2.   Selected claim and error data is collected and maintained on the TED Audit databases. These databases are then used to produce claims sampling and detail reports used by the auditors to audit each claim. After the claims have been audited, the system provides for automated collection of errors through on-line entry of payment and coding errors by the auditor to the claim audit database. The quarterly audit cycle is concluded with automated generation of final audit reports and, subsequently, rebuttal reports from claim and error data maintained on the audit databases. The audit databases retain claim and error data for each audit cycle for the current and previous quarters. This historical data allows for future creation of special post-audit reports for trend analysis and summary reporting.

C.   Description of Automated Functions. The automated function is designed to interface directly with the audit database to provide required data. A brief narrative description of the functions follows:

1.   Select Claim Sample.   The system is designed to provide an automated capability for selecting a random sample of claims to be audited. The claims are selected from edited submissions that pass the edit levels at TMA each quarter.

2.   Access Tables. Tables maintained in the audit database are available on-line during the processing of claim sampling reports.

a.   Three tables maintained on the audit database are available for online access and updating. They are:

(1)   Error Code Table - A table containing audit error codes.

(2) <u>Auditor ID Table</u> - A table used to identify individuals having authorized access to the automated systems.

b.   Other tables used by the system are available for online access by the auditors.   These tables are maintained and updated by either TMA or the input tapes from the MCSS contractor. They are:

(1)   Procedure Information

(2)   Pricing Information

(3)   Catchment Area Zip Codes

(4)   Provider Information

(5)   Catastrophic Cap and Deductible Information

3.   <u>Create Claim Sampling Reports (pre-audit reports).</u> This process creates reports based on claims selected for each contract each audit quarter. They are:

a.   <u>TED Audit Detail Report (TADR).</u>   Report #TA200-001 are produced for each claim selected for audit.   These reports contain detail claim data, all error codes with narrative definition that were identified by the claim audit system edits, table information extracted for the detail claim data, and the auditor error code applicable for each element in the claim.

b.   <u>TED ICN Listing Report (TADR).</u> Report #TA160-001 contains claim numbers for all claims selected for audit within a contract for the audit period.   These reports are used to request the hard copy claims and supporting documentation from the contractor.

4.   <u>Enter Audit Errors.</u> This is a process of entering audit errors, payment error amounts, or auditor comments to the claim audit database either during or upon completion of the audit of the hardcopy claims and payment records.

5.   <u>Create Final Audit Reports (post-audit reports).</u>   After all claims have been audited and audit errors have been entered in the TED Audit System, an auditor may request creation of a final audit report or a rebuttal report.   Final reports are then produced for the specified contract number and audit period from the data maintained on the claim audit database.   The final reports are:

a.   <u>Contractor TED Audit Summary Report</u>.   Report #TA280-001 provides the total number of errors for each claim type, total dollar amounts of payment errors and error rates.

b.   <u>TED Audit Analysis of Errors Report.</u>   Report #TA260-001 provides the number of errors assessed for each error type and category.

c.   <u>TED Audit Listing, Part I and II Report</u>. Report #TA240-001 provides a summary listing of payment and occurrence errors by ICN number.

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        d.   <u>TED Audit Error Report.</u>   Report #TA220-001 provides a report of all errors assessed by claim number and the auditor's comments (if any). This report is not produced when rebuttal reports are generated.

        6.   <u>Maintain History Data</u>. The audit database is updated with each sample selection and as each audit is entered. The database contains audit data for the current quarter and previous quarters for each contract. This allows for recovery of audit data for any audit period maintained in the history files.

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CHAPTER 3 - AUDITING SPECIAL CLAIM CONDITIONS

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<u>EXHIBITS</u>

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CHAPTER 3 - AUDITING SPECIAL CLAIMS CONDITIONS

CATASTROPHIC LOSS PROTECTION

For TRICARE Standard cost-share and deductible amounts are applied toward the catastrophic cap as the claims are processed for each fiscal year. For TRICARE Prime and TRICARE Extra claims, all beneficiary cost-share and deductibles specified in the contract shall be applied toward the cap, including nominal co-payments for outpatient care.

COMBINING IDENTICAL PROCEDURES ON A SINGLE PAYMENT RECORD DETAIL LINE

Combining charges for the same procedures having the same billed charges for health care service records, is optional with the contractor if the same action is taken with all. The option to combine like services shall be applied to those services rendered in the same calendar month. Any denied charges would have to be detailed into a separate line from those being allowed for payment. Reference: TRICARE Operations Manual, Chapter 6, Section 7.0.

COST-SHARE - ACTIVE DUTY INPATIENT

The per diem cost-share rate for active duty dependents' inpatient hospital claims changes yearly. See TRICARE Reimbursement Manual, Chapter 2, Section 1, for rates and effective dates.

DEFINITIONS - TMA

TMA definitions are contained in TRICARE Operations Manual, Appendices, Section A, 2.0.

DEVELOPMENT DOCUMENTATION

TRICARE Operations Manual, Chapter 8, Section 6, requires contractors to document development actions on the face of the claim or on attachments to the claim. Indicator codes in the history file or other electronic file are acceptable for audit purposes.

DOCUMENTATION OF MEDICAL REVIEW

TRICARE Operations Manual, Chapter 7, Section 1, requires different levels of medical reviews that must be documented. A stamp on the claim or other such indicator that a claim was routed to a "medical review" unit does not provide sufficient evidence that the claim was subjected to review. Supporting documentation of the reviewer's determination and rationale for approval or denial of coverage is required. However, the lack of such documentation is not necessarily an indication that a claim was incorrectly processed if there is other documentation with the claim that supports the pay/denial action. Errors are to be assessed if 1) prepayment medical review of the particular claim is a specific requirement in the TRICARE Operations Manual or TRICARE Policy Manual and 2) the documentation with the claim is not sufficient to support the contractor's processing action.

DOUBLE COVERAGE - ASSISTANCE PROGRAMS

CLAIMS AUDIT GUIDELINES

The law requires TRICARE to be secondary payer to everything but Medicaid. Unless a plan or program is specifically mentioned as an exception, TRICARE is secondary. Since no specific instructions have been issued regarding claims involving coverage by such assistance programs as the United Way, Easter Seal, Muscular Dystrophy, Crippled Children's Society, etc., TRICARE is to be considered secondary payer in these instances. Reference: TRICARE Reimbursement Manual.

DOUBLE COVERAGE VS CARE AUTHORIZATION/NONAVAILABILITY STATEMENTS

A CA/NAS is not required if the other insurance is primary payer, regardless of the coverage determinations on specific line items or the actual amounts paid by the other insurance.

DOUBLE COVERAGE - NON-DEVELOPMENT PAYMENT ERRORS

Auditors are to follow these guidelines in determining whether to assess errors on claims paid as TRICARE primary when the contractor does not submit documentation verifying that no double coverage exists:

    1.   No payment error will be assessed when:

        a.   The claim form contains no information regarding other coverage or
contains a negative indication; and

        b.   The contractor's claim history file indicates no other coverage within the twelve months preceding the earliest date of service; and

        c.   There is no information with the claim to suggest that the charges have
been submitted to, or paid by, other insurance.

    2.   Payment errors will be assessed when:

        a.   The claim form indicates other coverage which appears to be primary,
regardless of what is contained in the claims history file or

        b.   The claim history file contains evidence of other insurance coverage within 12 months preceding the earliest date of service, even though the claim does not indicate such coverage.

The above guidelines in no way negate the TRICARE Operations Manual requirement that, when double coverage is known, claims are to be accompanied by evidence of processing by the double coverage plan, i.e., a copy of an EOB from the other plan, evidence from the other plan that the services are not covered or an entry on the claim form made by the provider of the amount paid by the double coverage plan.

DOUBLE COVERAGE - SUPPLEMENTAL INSURANCE PLANS

In order to be considered supplemental coverage the plan must state that its benefits are payable only after a claim has been adjudicated by the primary coverage. Supplemental insurance plans are not considered double coverage.

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Income maintenance plans are also not considered double coverage. For more information reference TRICARE Reimbursement Manual, Chapter 4.

DRG - COORDINATION OF BENEFITS

Reference the TRICARE Reimbursement Manual, Chapter 4, Section 4.

DRG - DISCOUNT AGREEMENTS

Reference the TRICARE Reimbursements Manual, Chapter 3, Section 3.

DURABLE MEDICAL EQUIPMENT - PFPWD PRORATED

TRICARE Policy Manual Chapter 9, Section 15.1, outlines steps contractors are to take to process DME claims under PFPWD. The authorization allows a 90-day period during which the purchase of the DME must be made or else another authorization is required. The requirement for the authorization and its restriction to a 90-day period assures that the benefit is being extended for necessary equipment which is acquired at the time the need exists. The 90-day authorization period does not restrict the coverage of the DME to this time frame nor does it dictate the cost-sharing period.

FORMER SPOUSES

The TRICARE Policy Manual, lists conditions under which a former husband or wife of a member or former member is eligible for TRICARE.

CA/NAS - ANCILLARY CLAIMS

Contractors need not return inpatient ancillary claims for a copy of the CA/NAS if through reasonable efforts, a contractor can determine that the unprocessed claim is directly related to a CA/NAS indicator on the MHS Authorization and Referral System. Ancillary claims not having any of the documentation noted above or with no annotation will be counted as payment errors.

NUMBER OF SERVICES - PHYSICIAN DISPENSED DRUGS

The number of services for physician dispensed drugs is "one" for all drugs dispensed during a single visit. If a drug or drugs were dispensed at multiple visits, the number of services is equal to the number of visits during which drugs were dispensed.

PARTICIPATION AGREEMENT

Each claim completed by a non-network provider should show the provider's intentions regarding his or her TRICARE participation, i.e., acceptance of the TRICARE-determined allowable charge as payment for beneficiary's bill. If no intention is indicated, the claim may be processed as non-assigned or developed for the provider's intention to participate. A general assignment of benefits submitted with a claim is not acceptable documentation of a provider's intention to participate. If a provider representative of an institution that is Medicare participating, or subject to the RTC per diem payment system or the mental health per diem payment system, has properly signed the UB-92, or the HCFA 1500 block 1, but the Form Locator 53 has not been checked, the contractor can still process the claim as participating and

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need not develop it.   Reference: TRICARE Operations Manual, Chapter 6, Section 6.2.0.

PAYEE - NONPARTICIPATING CLAIMS

Generally, payments on nonparticipating claims or claims qualifying for a split payment are made to the individual signing the claim, the patient, or the sponsor.   In the absence of specific TMA policy, no errors will be assessed if payment is made to the beneficiary (either parent or guardian of a minor beneficiary) or sponsor regardless of who signs the claim. (Issues involving the custody of minors or absence of a sponsor from the home are not relevant for determining payee and are generally considered to be domestic matters.) Payments made to beneficiaries under 18 years of age will be considered errors unless the claim contains services for a confidential diagnosis or the beneficiary is a spouse of a sponsor.   Payments made to deceased beneficiaries or to the sponsor, spouse, or next-of-kin of a deceased beneficiary without documentation that the payee is the legal representative of the estate will be considered payment errors.

PAY GRADES

Exhibit 1 of this chapter lists comparable ranks for the Armed Forces and their abbreviations.

SIGNATURE - BENEFICIARY

Every claim must bear the signature of the patient or other authorized person to verify that services were rendered and the Government has a legal liability to pay.   With some exceptions, unsigned claims must be returned under control for an authorized signature.   Reference TRICARE Operations Manual, Chapter 8, Section 4, for additional information.

SIGNATURE - DECEASED BENEFICIARY

If the beneficiary is deceased, the claim must be signed by the legal representative of the estate.   If there is no estate (and thus no legal representative), the claim may be signed by sponsor, spouse, or next of kin. For the signature of these individuals to be acceptable, a statement must be submitted that no legal representative has been appointed.   Payment errors will be assessed if the necessary documentation is not included with the claim for audit.   Reference: TRICARE Operations Manual, Chapter 8. Section 4.5.0.

SIGNATURE - PROVIDER

On all non-network participating claims and on nonparticipating claims which contain itemization of services on the form in lieu of a separate provider billing, the provider's signature or an acceptable facsimile must be entered. Reference: TRICARE Operations Manual, Chapter 8, Section 4 paragraphs 9.0 and 10.0 for additional information.

CLAIMS AUDIT GUIDELINES

ARMED FORCES RANKS AND ABBREVIATIONS

<u>EXHIBIT 1</u>

PAY GRADE	RANK ABBREV	RANK	TITLE FOR SALUTATION
		<u>ARMY</u>	
O-10	GEN	General	General
O-9	LTG	Lieutenant General	General
O-8	MG	Major General	General
O-7	BG	Brigadier General	General
O-6	COL	Colonel	Colonel
O-5	LTC	Lieutenant Colonel	Colonel
O-4	MAJ	Major	Major
O-3	CAP	Captain	Captain
O-2	1LT	First Lieutenant	Lieutenant
O-1	2LT	Second Lieutenant	Lieutenant
W-4	CW4	Chief Warrant Officer	Mr. Miss Mrs.
W-3	CW3	Chief Warrant Officer	Mr. Miss Mrs.
W-2	CW2	Chief Warrant Officer	Mr. Miss Mrs.
W-1	WO1	Warrant Officer	Mr. Miss Mrs.
E-9	CSM	Command Sergeant Major	Sergeant Major
E-9	SGM	Sergeant Major	Sergeant Major
E-8	1SG	First Sergeant	First Sergeant
E-8	MSG	Master Sergeant	Sergeant
E-7	SFC	Sergeant First Class	Sergeant
E-7	SFC	Platoon Sergeant	Sergeant
E-6	SSG	Staff Sergeant	Sergeant
E-5	SGT	Sergeant	Sergeant
E-4	CPL	Corporal	Corporal
E-4	SP4	Specialist 4	Specialist
E-3	PFC	Private First Class	Private
E-2	PVT	Private	Private
E-1	PVT	Private	Private
		<u>AIR FORCE</u>	
O-10	GEN	General	General
O-9	LtGen	Lieutenant General	General
O-8	MajGen	Major General	General
O-7	BrigGen	Brigadier General	General
O-6	Col	Colonel	Colonel
O-5	LtCol	Lieutenant Colonel	Colonel
O-4	Maj	Major	Major
O-3	Capt	Captain	Captain
O-2	1LT	First Lieutenant	Lieutenant
O-1	2LT	Second Lieutenant	Lieutenant
W-4	CW4	Chief Warrant Officer	Mr. Miss Mrs.
W-3	CW3	Chief Warrant Officer	Mr. Miss Mrs.
W-2	CW2	Chief Warrant Officer	Mr. Miss Mrs.
W-1	WO1	Warrant Officer	Mr. Miss Mrs.

<u>AIR FORCE cont.</u>

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ARMED FORCES RANKS AND ABBREVIATIONS

EXHIBIT 1

PAY GRADE	RANK ABBREV	RANK	TITLE FOR SALUTATION
E-9	CSMgt	Chief Master Sergeant	Sergeant
E-8	SMSgt	Senior Master Sergeant	Sergeant
E-7	MSgt	Master Sergeant	Sergeant
E-6	TSgt	Technical Sergeant	Sergeant
E-5	SSgt	Staff Sergeant	Sergeant
E-4	Sgt	Sergeant	Specialist
	SrA	Senior Airman	Airman
E-3	PFC	Airman First Class	Airman
E-2	PVT	Airman	Airman
E-1	PVT	Airman Basic	Airman

MARINE CORPS

PAY GRADE	RANK ABBREV	RANK	TITLE FOR SALUTATION
0-10	GEN	General	General
0-9	LTG	Lieutenant General	General
0-8	MG	Major General	General
0-7	BG	Brigadier General	General
0-6	COL	Colonel	Colonel
0-5	LTC	Lieutenant Colonel	Colonel
0-4	MAJ	Major	Major
0-3	CAP	Captain	Captain
0-2	1LT	First Lieutenant	Lieutenant
0-1	2LT	Second Lieutenant	Lieutenant
W-4	CW4	Chief Warrant Officer	Mr. Miss Mrs.
W-3	CW3	Chief Warrant Officer	Mr. Miss Mrs.
W-2	CW2	Chief Warrant Officer	Mr. Miss Mrs.
W-1	WO1	Warrant Officer	Mr. Miss Mrs.
E-9	SgtMaj	Sergeant Major	Sergeant Major
E-9	MGysgt	Master Gunnery Sergeant	Master Gunnery Sergeant
E-8	1st Sgt	First Sergeant	First Sergeant
E-8	Msgt	Master Sergeant	Master Sergeant
E-7	GySgt	Gunnery Sergeant	Gunnery Sergeant
E-6	SSgt	Staff Sergeant	Staff Sergeant
E-5	Sgt	Sergeant	Sergeant
E-4	Cpl	Corporal	Corporal
E-3	LCpl	Lance Corporal	Corporal
E-2	PFC	Private First Class	Private
E-1	PVT	Private	Private

NAVY AND COAST GUARD

PAY GRADE	RANK ABBREV	RANK	TITLE FOR SALUTATION
0-10	ADM	Admiral	Admiral
0-9	VADM	Vice Admiral	Admiral
0-8	RADM	Rear Admiral	Admiral
0-7	RADM	Rear Admiral	Admiral
0-6	CAPT	Captain	Captain
0-5	CDR	Commander	Commander

CLAIMS AUDIT GUIDELINES

ARMED FORCES RANKS AND ABBREVIATIONS

EXHIBIT 1

PAY GRADE	RANK ABBREV	RANK	TITLE FOR SALUTATION
0-4	LCDR	Lieutenant Commander	Commander
0-3	LT	Lieutenant	Lieutenant
0-2	LTJG	Lieutenant Junior Grade	Lieutenant
0-1	ENS	Ensign	Ensign
W-4	CWO-4	Chief Warrant Officer	Chief Warrant Officer
W-3	CWO-3	Chief Warrant Officer	Chief Warrant Officer
W-2	CW-O2	Chief Warrant Officer	Chief Warrant Officer
W-1	WO-1	Warrant Officer	Warrant Officer
E-9	MCPO	Master Chief Petty Officer	Master Chief Petty Officer
E-8	SCPO	Senior Chief Petty Officer	Senior Chief Petty Officer
E-7	CPO	Chief Petty Officer	Chief Petty Officer
E-6	P01	Petty Officer First Class	Petty Officer
E-5	P02	Petty Officer Second Class	Petty Officer
E-4	P03	Petty Officer Third Class	Petty Officer
E-3	SN	Seaman	Seaman
E-2	SA	Seaman Apprentice	Seaman
E-1	SR	Seaman Recruit	Seaman

E-4	E-5	E-6	E-7	E-8	E-9
ABM13	A02	AC1	AOC	BMCS	BMCM
FTM3	AMS2	BM1	BMC	MRCS	BTCM
GMG3	BM2	HT1	AMHC		
BM3	HT2	MS1	PNC		
YN3	SKZ	EM1	AEC		
PN3	CS2	YN1	ATC		
		LNI			

EXAMPLES OF NAVY & COAST GUARD RATINGS WITHIN PAY GRADES*

*To convert a rating into the rated into the related pay grade, note the last numeric or alpha character.

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CHAPTER 4 - AUDITING TED DATA ELEMENTS

This chapter provides special guidance for auditing the data on the TRICARE Encounter Data (TED) Record. The names of the fields are arranged in alphabetical order with the corresponding TED Audit Detail Report (TADR) audit code following the name of each field. The discussion of payment errors under each data field is intended to provide the auditor with an indication of the types of payment errors that may be related to a particular data field. Chapter 5 provides more information on determining errors, and Exhibit 1 of Chapter 5 lists all the audit codes related to the various data fields and types of errors.

ADJUSTMENT/DENIAL REASON CODE (04H on institutional record and 26I on non-institutional TED Record) which is a 5 position alphanumeric field that identifies the reason for nonpayment of services or adjustment of the detail line item. It is required if services are not allowed. Leave blank if not applicable.

   Payment Error: Claims denied or allowed in error are payment errors.

ADMISSION DATE (01D) This is an 8 position alphanumeric field (YYYYMMDD) on the institutional record which is the date the patient was first admitted to the institution for that episode. The admission date is found in UB-92 Form Locator 17. This is required information.

   Payment Error: None.

ADMISSION DIAGNOSIS (01E) This is a 6 position alphanumeric field on the institutional record which is the ICD-9-CM code to identify diagnosis under which the patient was admitted to the institution. The code must be the most detailed subcategory or sub-classification and left justified to include leading zeros and blank fill. All zeros are not permitted. The admitting diagnosis can be found in UB-92 Form Locator 76. This is required information.

   Payment Error: A payment error may be assessed when the admitting diagnosis does not substantiate an emergency admission and an NAS is required but absent.

AMOUNT ALLOWED (Total) (02G) This is a 9 position signed numeric field which includes 2 decimal places. The amount allowed field is used on the institutional record and is the total amount allowed for all authorized services on the TED Record. If the complete TED Record is denied (Type of Submission "D") this amount must be zero. This data is required unless a unique health care plan allows only partial submission of the financial data.

   Payment Error: The following conditions may constitute payment errors:

   1.   Incorrect determination of allowable charge (billed, DRG calculation or per diem) on any service/procedure causing error in total amount allowed.

   2.   Omission of a billed charge may cause error in allowable amount.

   3.   Inclusion of extra charges not shown on claim may cause error in allowable amount.

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AMOUNT ALLOWED BY PROCEDURE CODE (17I) This is an 9 position signed numeric field including 2 decimal places and is the total amount allowed for the service(s)/supply(ies). This field is applicable only on non-institutional records. The amount allowed is determined based on prevailing rate, conversion amount, billed amount, negotiated rates, or manual pricing. Zeros are to be entered if a claim is denied. This is required information.

Payment Error: The following conditions may represent payment errors:

1.   Incorrect determination of allowable charge due to incorrect procedure code, number of services, billed amount, etc.

2.   Incorrect pricing methodology used.

AMOUNT APPLIED TOWARD DEDUCTIBLE by PROCEDURE (19I) This is a 5 position field including two decimal places which is that portion of the amount allowed which is applied toward the patient or family deductible. The data is required on the non-institutional record unless a unique health care plan allows only partial submission of the financial data. A value is not required on the institutional record.

Payment Error: The following conditions may represent payment errors:

1.   Claim or portion of claim not applied to deductible resulting in excess payment. The amount of the excess payment is the payment error amount.

2.   Claim or portion of claim applied to deductible in error regardless of whether the claim is paid or denied. The amount of the deductible which is the government's cost-share is the payment error amount.

3.   Failure to apply other health insurance payment to deductible. The amount which should be applied to the deductible is the payment error amount.

AMOUNT BILLED (TOTAL) (01G) This is an 9 position signed numeric field including 2 decimal places. The amount billed total field is on the institutional TED Record which is the total amount billed for all reported services. The amount billed must be the sum of all total charges per revenue codes on the institutional record. This is required

Payment Error: The following conditions may constitute payment errors:

1.   Incorrect calculation of total itemized charges.

2.   Portion of charges omitted.

3.   Inclusion of charges not shown on claim or itemization.

AMOUNT BILLED BY PROCEDURE CODE (16I) This is an 9 position signed numeric field on the non-institutional TED Records which is the amount billed by the provider for this (these) service(s)/ supply(ies). Combining charges for the same procedures having the same billed charges under the contractor's operation is optional with the contractor if the same action is taken with all. The option to combine like services shall be applied to those services rendered the same calendar month.

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If a lump charge is billed on the claim for several procedures, the contractor must develop for a breakdown of charges unless the billing is for outpatient care from a hospital. This is a required field.

   Payment Error: The following may result in payment errors:

   1.   Amount entered for a distinct service differs from the amount on the claim form or itemized bill.

   2.   Incorrect aggregate total entered for multiple services on one line.

   3.   Charges not separated (lump amount) for several different procedures processed
without adequate documentation or breakdown of charges.

   4.   Charges not billed on the claim, but appearing on other insurance EOB/worksheet entered as part of the claim.

   5.   Combined charges that spans two pricing profiles.

AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) (05G) This is a 9 position signed numeric field including 2 decimal place, which is that portion of total amount allowed that was paid by government contractor for the services reported on the TED Record. This is required data on the institutional records. The field reflects the total amount paid regardless of a providers financial arrangement with the contractor, i.e., "withhold amounts'.

The amount due is determined as follows:

   1.   If other insurance is involved, the TRICARE payment is calculate using the three step computation contained in the Operations Manual.

   2.   If other insurance is involved and the claim is for inpatient hospital care from a nonexempt DRG provider, the TRICARE payment will be calculated as described in the TRICARE Reimbursements Manual, Chapter 4, Section 3.

   Reference: TRICARE Reimbursements Manual, Chapter 4, Section 3; and TRICARE Systems Manual Chapter 2. Locator 1-140.

   Payment Error: The following may constitute payment errors:

   1.   Amount of payment is incorrect.

   2.   Non-payable claim paid and vice versa.

   3.   Payment made to wrong provider.

   4.   Payment duplicates payment on previous claim.

AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE (20I) This is a 9 position signed numeric field including 2 decimal place, which is that portion of amount allowed that was paid by government contractor for all services on this line item as reported on the TED Record. This is required data on the institutional records. The field reflects the total amount paid

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regardless of a providers financial arrangement with the contractor, i.e., "withhold amounts'.

The amount due is determined as follows:

1.   If no other insurance is involved, the amount will be the allowed amount per line item less deductible and patient cost-share.

2.   If other insurance is involved, the TRICARE payment is calculate using the three step computation contained in the Operations Manual.

3.   If other insurance is involved and the claim is for inpatient hospital care from a nonexempt DRG provider, the TRICARE payment will be calculated as described in the TRICARE Reimbursements Manual, Chapter 4, Section 3.

Reference: TRICARE Reimbursements Manual, Chapter 4, Section 3; and TRICARE Systems Manual Chapter 2. Locator 2-205.

Payment Error: The following may constitute payment errors:

1.   Amount of payment is incorrect.

2.   Non-payable claim paid and vice versa.

3.   Payment made to wrong provider.

4.   Payment duplicates payment on previous claim.

AMOUNT PAID BY OTHER HEALTH INSURANCE (OHI) (03G) This is an 9 position signed numeric field including 2 decimal places. This data field is on both the institutional and non-institutional TED Record. The total amount paid by OHI includes TPL for all services on the institutional record, and service(s) on each line item on the non-institutional record. Any inpatient/ institutional claim that has a diagnosis code in the ICD-9-CM diagnosis code range of 800-999.9 regardless of the dollar value, and any outpatient/non-institutional claim within the same range with billed charge of $500 or more, are considered potential TPL claims. This is required.

Payment Error: Any claim that falls within the diagnosis and billed charge parameters where no OHI development or information is included may result in a payment error.

AMOUNT PATIENT COST-SHARE (TOTAL) (04G) This is a 9 position signed numeric filed including 2 decimal places the institutional TED Record. This field represents the total amount of money the beneficiary is responsible for paying in connection with covered services, other than any disallowed amounts. This is required information.

Payment Error: The following may result in payment errors:

1.   Incorrect determination of the allowed amount.

2.   Incorrect application of the outpatient deductible.

3.   Incorrect Health Care Coverage (HCC) Member Category.

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    4.   Incorrect Type of Service, e.g., inpatient verses outpatient.

AMOUNT PATIENT COST-SHARE BY PROCEDURE (18I) This is a 9 position signed numeric filed including 2 decimal places on the non-institutional TED Record. This field represents the total amount of money the beneficiary is responsible for paying in connection with covered services, other than the annual fiscal year deductible and any disallowed amounts. This is required information.

    Payment Error: The following may result in payment errors:

    1.   Incorrect determination of the allowed amount.

    2.   Incorrect application of the outpatient deductible.

    3.   Incorrect Health Care Coverage (HCC) Member Category.

    4.   Incorrect Type of Service, e.g., inpatient verses outpatient.

BEGIN DATE OF CARE (Institutional) (05D) This is an 8 position alphanumeric field which contains a YYYYMMDD value and is the earliest date of care reported on the TED Record. If the record has a Frequency Code of '3' Interim, or '4' Final, the BEGIN DATA OF CARE must match (plus or minus 1 day) the ENDING DATE OF CARE on the previous TED Record submitted. This is required information.

    Payment Error: The following may constitute payment errors:

    1.   Date of service is past the claims filing deadline and no waiver has been granted by the contractor.

    2.   Beneficiary is ineligible on correct date of care. (Refer to TRICARE Reimbursement Manual, Chapter 6, Section 2 for the effects of ineligibility on DRG priced claims.)

BEGIN DATE OF CARE (Non-Institutional) (22I) This is a 8 position alphanumeric field which contains YYYYMMDD values on the TED Record. This field contains the earliest beginning date of the provider's services for this procedure. This is required information.

    Payment Error: The following may constitute payment errors:

    1.   Inclusive dates of care overlap two fiscal years, which results in incorrect deductible.

    2.   Date of service is past the claims filing deadline and no waiver has been granted by the managed care contractor.

    3.   Beneficiary is ineligible on date of care.

    4.   Provider is not authorized for date of care.

CA/NAS EXCEPTION REASON (11A on institutional records and 03I on non-institutional records). This is a 2 position alphanumeric field on both institutional and non-institutional TED Records that describes the reason for bypassing the requirement of a CA/NAS. All contractors are required to process for CA/NAS for Inpatient Mental Health Care. When no CA/NAS

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exceptions apply for inpatient MH care, for beneficiaries residing within the catchment area, the field must be blank. The field must also be blank if the beneficiary resides outside a catchment area. Reference: TRICARE Policy Manual Chapter 1, Section 6.1 for additional information.

Payment Error: The following situations may result in payment errors:

1.   Beneficiary zip code indicates CA/NAS is required, no exception reasons apply and CA/NAS Statement is not with claim.

2.   CA/NAS Exception Reason coded when none apply and payment made based on exception code.

CA/NAS NUMBER (12A on institutional records and 04I on non-institutional records). This is an 15 position alphanumeric field on both the institutional and non-institutional TED Records that is the unique number assigned by the MTF when issuing the CA/NAS. Care authorization is also issued by the MTF. Both numbers are carried on the MHS Authorization and Referral System. Download from the MHS Authorization and Referral System (or from hardcopy if attached to claim). This is required information if available. The CA/NAS number represents the following information:

1.   The first 4 digits are the Data Management information System (DMIS) facility identifier.

2.   The next 8 digits represent the date the form is issued and is in YYYYMMDD format.

3.   The final 3 digits are the facility sequence number.

Payment Error: If the CA/NAS number does not correspond to the inpatient admission for this TED Record a payment error may be assessed.

CA/NAS REASON FOR ISSUANCE (13A on institutional records and 05I on non-institutional records). This is a 1 alphanumeric field on both the institutional and non institutional TED Record. The CA/NAS Reason For Issuance indicates why the care was not or cannot be provided by a Military Treatment Facility. Download from the MHS Authorization and Referral System (or from hardcopy if attached to claim). For additional information on the MHS Authorization and Referral System, reference the TRICARE Systems Manual, Chapter 4. This is required information if available.

COVERED DAYS (08D) This is a 3 position signed numeric field on institutional claims which contains the number of hospital days authorized for all services within the TED Record. The number of hospital days where there was any allowance by the contractor. For admit through discharge statement, enter the number of hospital days where there was any allowance by the contractor. For initial, interim or final statement enter the number of allowed days in the period covered by the TED Record. Example of determination of interim/final bill hospital days:

    Initial Billing - Admitted March 10
        Billing is through March 31. Number of days = 22.

    Interim Billing - First date is April 1
        Billing is through April 30. Number of days = 30.

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Final Statement - First date is May 1.
      Discharge date is May 21. Number of days = 20.

Payment Error: Incorrect calculation of hospital days resulting in incorrect allowance of room charges or erroneous calculation of patient cost-share may be assessed payment errors.

DATE TED RECORD PROCESSED TO COMPLETION (06A) This is an 8 position alphanumeric field on both the institutional and non-institutional records which contains the values YYYYMMDD and is the date the contractor processed the claim/treatment encounter data to completion. This is when all services and supplies on the claim have been adjudicated, payment has been determined, deductible has been applied, checks and EOBs have been prepared for mailing, and payment/deductible/denial has been posted to history and the TED Record(s). This date does not change for resubmissions unless previously coded in error. This is required information.

Payment Error: None.

DRG NUMBER (17E) This is a 3 position alphanumeric field which identifies the Diagnosis Related Group (DRG) determined for this care on an institutional record. This is required if the TED Record is processed under the TRICARE DRG reimbursement methodology. The auditor will verify the TED Record entry with the 3M Health Systems Information (HIS) DRG Grouper program on the personal computer.

Payment Error: The following may constitute payment errors:

1.   Payment based on erroneous DRG number.

2.   DRG reimbursement for number exempt from DRG payment.

3.   Erroneous outlier determinations.

4.   DRG payment based on erroneous weighing factors.

END DATE OF CARE (Institutional) (06D) This is an 8 position alphanumeric field which contains a YYYYMMDD value and is the latest date of care reported on the institutional TED Record. This is required information.

Payment Error: The following may constitute payment errors:

1.   Date of service is past the claims filing deadline and no waiver has been granted by the MCSS contractor.

2.   Beneficiary is ineligible on date of care.

END DATE OF CARE (Non-Institutional.) (23I) This is a 8 position alphanumeric field which contains YYYYMMDD values on the non-institutional record. This field contains the latest ending date of the provider's services for that procedure. This is required information.

Payment Errors: The following may constitute payment errors:

1.   Inclusive dates of care overlap two fiscal years, which adversely affects the deductible.

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2.   Date of service is past the claims filing deadline and no waiver has been granted
by the contractor.

3.   Beneficiary is ineligible on date of care.

ENROLLMENT/HEALTH PLAN CODE (11B) This is a 2 position alphanumeric field on bcth the institutional and non-institutional TED Record which indicates whether the patient is enrolled with the contractor (Prime) or not (Non-Prime), or the care was received under the Standard TRICARE Program or a special care program. This is required information which must be entered.

Payment Error: A payment error exists if the contractor processed the claim under the incorrect enrollment status which resulted in an overpayment or underpayment.

FILING DATE (01A) This is a 7 position alphanumeric field with YYYYDDD value which is the date the request for payment of services rendered was received by the contractor for processing. This field is part of the Internal Control Number group composed of the Filing Date, Filing State/Country Code, and Sequence Number.   Generally, the date entered by the contractor is not questioned unless there is evidence that it is incorrect, e.g., the date is earlier than a date of service on the claim or the claim is a reprocessing of a previously denied claim and has not been assigned a new claim number. This is required data on both the institutional and non-institutional records.

Payment Error: If the filing date is earlier than the date of services on the claim, a payment error may exist if the MCSS contractor paid for services not yet rendered.

FILING STATE/COUNTRY CODE (02A) This is a 3 position alphanumeric field that indicates the State or Country where the primary care was provided. This field is part of the Internal Control Number group composed of the Filing Date, Filing State/Country Code, and Sequence Number. This information is required on both institutional and non-institutional records.

Payment Error: Claims processed for care provided outside the contractor's contractual
jurisdiction would result in a payment error.

FREQUENCY CODE (07D) This is a 1 position alphanumeric field on the institutional TED Record that describes the frequency of billing from the institution. All TED Records for interim (interim or final) institutional bills must be submitted as an adjustment using the same ICN as the initial submission. On the UB-92 claim form, the frequency information can be found at Form Locator 4.

The Initial, Interim, and Final TED Records, when used, must be submitted in correct sequence. If the patient is transferred and the care is processed under DRG rules, the Code '1' must be used; all other transfers must use Code '1' or '4' as appropriate. This is required information.

Payment Error: A non-qualifying interim claim processed for payment under the DRG pricing methodology may result in a payment error.

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HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (09B) This is a 1 position alphanumeric field on both institutional and non-institutional TED Records which indicates the members category code during the Health Care Coverage period as verified through DEERS. This is a required field.

    Payment Error: A patient cost-share error due to incorrect status code may result in a payment error.

HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (10B) This is a 1 position alphanumeric field on both the institutional and non-institutional TED Record which defines the members relationship code for the Health Care Coverage period as verified through DEERS. This is required information.

    Payment Error: The following may result in payment errors:

    1.   Payment based on incorrect relationship of former spouse (H), (I), or (J),

    2.   Payment made when sponsor is active duty and relationship is sponsor verses self.

NUMBER OF SERVICES (15I) This is a 2 position signed numeric field on the non-institutional record which is the number of procedures performed/services or supplies rendered for medical, dental, and mental health care. Identical procedures must be combined when performed by the same provider, with the same charge for each, and within the same calendar month, provided the reason for allowance/denial is the same for each charge, with the exception of psychiatric procedures. For ambulance services, allergy testing, DME rental. POV mileage for PFPWD, or anesthesiology, enter 01 for each service regardless of length of time, number of base units or mileage. Allowed prescription drugs must be combined separately from disallowed prescription drugs. For prescriptions report the number of prescriptions. This is required information.

    Payment Error: An-incorrect entry which results in an erroneous calculation of the amount allowed may result in an incorrect payment.

OCCURRENCE/ LINE ITEM NUMBER (05H on institutional records and 13I on non-institutional records).   This is a 3 position numeric field which is the unique number for each utilization or revenue data occurrence within the TED Record. Line item must be assigned in sequential ascending order. This is required information on the TED Record.

    Payment Error: None.

OVERRIDE CODE: (07A) This is a 6 position alpha field that provides indication that questionable information has been verified on both institutional and non-institutional records. This data is required if an override code is applicable to override TMA edit checking. One to three codes may be reported in the field and must not be duplicated. The field must be left justified and blank filled. The only codes that are valid are those listed in the TRICARE Systems Manual, Chapter 2, Section 2.6 (M-O).

    Payment Error: The following may result in payment errors when an override code is incorrectly used:

    1.   Patient is over age 65.

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2.   Good faith claim payment has been made.

3.   Claim filed after the filing deadline.

4.   Patient is family member 21 years of age or older and not enrolled in a school of higher learning.

5.   Patient is family member of an active duty sponsor and cost-share is based on both current and prior admission (institutional only).

6.   Catastrophic cap limit has not been reached.

7.   Diagnosis/procedure code for female; sex indicates male.

PATIENT STATUS (04D) This is a 2 position alphanumeric field that indicates the patient status as of the end date of care on the TED Record for institutional claims. The discharge status can be found on the UB-92 claim form under the heading 'patient status' in Form Locator 22. This is required information.

Payment Error: The following may constitute payment errors:

1.   DRG payment erroneously based on a transfer instead of discharge and vice versa.

2.   DRG payment when patient status is "remaining" except when claim qualifies for interim payment.

PATIENT ZIP CODE (05B) This is a 9 position alphanumeric field on both the institutional and non-institutional TED Records which is the US Postal Zip Code or foreign country code for patient's legal residence at the time service was rendered and must not be the zip code of a P.O. Box. Field must be a valid 5 or 9 digit zip code. If only 5 digits, left justify and blank fill to right. If a foreign country, must be a 3 character foreign country code, left justified and blank filled. The contractor is not responsible for an error if the entry on the claim is incorrect.

The address on the EOB/check must agree with that on the claim form or attachment to assure deliverability unless there is some evidence that the patient has subsequently moved or that a secondary mailing address is appropriate, e.g., address of a custodial parent. The patient zip code must be the residence at the time the care was rendered. This is required information.

Payment Error: A payment error exists if, because of an incorrect zip code, a claim is paid when a valid CA/NAS is required and not provided or, conversely, if a claim is denied for lack of a CA/NAS when one is not required.

PAY GRADE (SPONSOR) (07B) This is a 2 position alphanumeric field on both institutional and non-institutional TED Record which represents the level of pay. (The combination of pay plan code and pay grad code represents the sponsor's pay category.) The contractor must download this information from DEERS and, if unavailable, report the pay grade from the claim. This is a required field.

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Payment Error: PFPWD health care service records containing an incorrect sponsor's pay grade which results in an erroneous co-payment may result in a payment error.

PERSON BIRTH CALENDAR DATE (PATIENT) (03B) This is an 8 position alphanumeric field which contains the values YYYYMMDD on both institutional and non-institutional TED Records. This is the date when a human being was born as verified through DEERS. The persons birth calendar date in some instances determines the patient's continued eligibility under the program. Children lose TRICARE eligibility at age 21 unless handicapped or enrolled as a full time student in a school of higher learning. Student eligibility terminates at age 23. DEERS or the patient's ID card must reflect the continued eligibility for claims to be paid. Reference: TRICARE Systems Manual, Chapter 3 for specific instructions.

The auditor will verify that the correct DOB is coded and confirm eligibility and age on DEERS. If the patient is over age 21 or the patient is over 65, the auditor will verify the appropriate coding of the Override Code. This is required information.

Payment Errors: Payment of claims for services to an individual who lost eligibility, or denial of claims for services to an individual who is eligible will result in a payment error.

PERSON IDENTIFIER (PATIENT) (02B) This is a 9 position alphanumeric field on both the institutional and non-institutional TED Record. This field contains the identifier that represents a human being. This attribute will usually contain the Person's Social Security Number as verified through DEERS.

Payment Error: An incorrect application of deductible or patient's cost-share will result in a payment error.

PERSON IDENTIFIER (SPONSOR) (06B) This is a 9 position alphanumeric field on both institutional and non-institutional TED Record which is the identifier that represents a person who is a sponsor. This attribute will usually contain the sponsor's Social Security Number, as verified through DEERS. This is required information.

Payment Error: An incorrect application of a deductible or patient cost-share may result in payment errors.

PERSON NAME (PATIENT) (0IB) This is not a data element but a group of data elements related to the institution and non-institution TED record. This field is comprised of the Person Last Name, Person First Name, Person Middle Name, and Person Cadency Name as verified by DEERS. The Person Last Name is a 25 position character field, the Person Last Name is a 35 digit character field, the Person Middle Name is a 25 digit character field, and the Person Cadency Name (i.e., Sr. Jr., III., etc) is a 10 character field. All fields are alphanumeric which are downloaded from DEERS. Required if available on DEERS, if not available, blank fill..

Payment Error: Incorrect coding of the patient's name may cause an incorrect deductible or patient cost-share.

PERSON SEX (PATIENT) (05B) This is a 1 position alphanumeric field on both the institutional and non-institutional TED Record that defines the sex of

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the patient.   This information must be downloaded from DEERS.   This is required information.

    Payment Error: None.

PLACE OF SERVICE (24I) This is a 2 position alphanumeric field on the non-institutional TED Record which indicates the location of provided health care, e.g., inpatient-hospital, doctor's office, ambulance, etc.   This is required information.

    Payment Error: Incorrect place of service may cause payment errors due to benefit determinations, pricing errors, etc.

PRICING RATE CODE (10A on institutional records and 21I on non-institutional records).   This is a 2 position alphanumeric field on both the institutional and non-institutional TED Record which indicates the contractor's pricing methodology used in determining the amount allowed for the service(s)/supplies.   Reference: TRICARE Systems Manual, Chapter 2, Section 2.7 (P) for additional instruction and a complete list of codes.   This is required information.

    Payment Error: The following may result in payment errors:

    1.   Incorrect pricing methodology causing an error in the amount allowed.

    2.   Service/supply incorrectly denied.

    3.   Service/supply incorrectly allowed.

    4.   Payment not in compliance with applicable special rate, e.g., DRG, or payment based on special rate when none applies.

PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE (11E) This is a 5 position alphanumeric field on the institutional record that identifies the principal procedure performed during the period covered by this TED Record as coded on the UB-92.   On the UB-92 claim form, this data is found in Form Locator 80. The most current procedure code edition (ICD-9-CM) as directed by TMA, and the most detailed code provided must be used.   The field must be left justified and blank filled.   The decimal point is not coded and is always assumed to follow the second position.   This is required information when Revenue Codes 36X or 72X are present.   The field is to be blank filled if not applicable.

    Payment Error: A claim paid without evidence of prepayment medical review when required based on procedure code may result in a payment error.

PRINCIPAL TREATMENT DIAGNOSIS (01F on non-institutional records or 02E institutional records).   This is a 6 position alphanumeric field on both institutional and non-institutional TED Records.   This is the condition established, after study, to be the major cause for the patient to obtain medical care as coded on the claim form or otherwise indicated by the provider.   Use the most current diagnosis code edition (ICD-9-CM), as directed by TMA.   Must provide the most detailed code.   Left justify and blank fill.   Do not code the decimal point as it is always assumed to be following the second position.   The principal treatment diagnosis is generally needed for making determinations about whether or not services are

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covered, medically necessary, and consistent with other claims data or patient history.

The exact coding taken from the UB-92 must be used on institutional claims, however, on non-institutional claims, the auditor has discretion for the code used. If both a code and a narrative description are given by the provider, but are inconsistent with each other the narrative takes precedence in determining the code to be used. This is required.

    Payment Error: The following may result in payment errors:

    1.   Principal Treatment Diagnosis indicates that services are not covered, but were allowed.

    2.   Principal Treatment Diagnosis indicates that services are covered, but were denied.

    3.   Principal Treatment Diagnosis is missing, incomplete or unclear to support payment determination.

    4.   Medical review required but not performed. Justification for payment is questionable.

    5.   Payment made without development for diagnosis; no documentation to support code used.

PROCEDURE CODE (14I) This is a 5 position alphanumeric field on the non-institutional TED Record which indicates the procedure which describes the care received. Procedures must be coded in accordance with the Physician's Current Procedural Terminology (CPT-4), or HCPCs National Level II Medicare Codes or TMA approved codes. If the contractor is using a different internal coding structure, there must be proper conversion to the approved coding on the TED Record. Providers may submit procedure codes in lieu of narrative descriptions.   If the provider furnishes an acceptable code plus a nonspecific narrative which does not essentially contradict the code, the code may be used to code (price) the service without further consideration. If the code and narrative disagree, the claim must be developed. A "not elsewhere classified" (NEC) code is to be used only where there is no established procedure code. However, if a specific narrative is provided which is inconsistent with the code, the code representing the narrative can be used without development. This is required information.

    Payment Error: Payment errors may result in situations involving use of an incorrect procedure code, unjustified change of a submitted code, or inappropriate use of an NEC code which causes incorrect pricing, denial of a benefit, or failure to apply required medical review guidelines.

CPT-4 MODIFIER (27I) This is a 2 position alphanumeric field per line item on the non-institutional TED Record which provides the means by which the health care professional can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. (Refer to Physician's Current Procedural Terminology (CPT-4), or HCPCs National Level II Medicare Codes). This is required information if available.

    Payment Error: Payment errors may result in situations involving use of an incorrect procedure code modifier, unjustified change of a submitted

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code, or inappropriate use of an NEC code which causes incorrect pricing, denial of a benefit, or failure to apply required medical review guidelines.

PROVIDER NETWORK STATUS INDICATOR (03C on institutional records and 08I on non-institutional records). This is a 1 position alphanumeric field on both institutional and non-institutional TED Records which indicates whether the provider is a network or non-network provider. This is required information.

     Payment Error: A payment error may exist if the provider was paid by the contractor or subcontractor as a contracted provider when the provider was not under a contract and vice versa.

PROVIDER SPECIALTY (07C on institutional records and 11I on non-institutional records).   This is a 10 position alphanumeric field that describes a non-institutional provider's specialty. The provider specialty on the TED Record must match the provider major specialty code in the corresponding record in the provider file and be compatible with the type of services provided. For example, if the payment record shows specialty 59 (ambulance) and type of service is psychotherapy, an occurrence error would be assessed for incorrect specialty code.   Since the TRICARE Operations Manual does not provide specific instructions, contractors can code "clinics" with the specialty code "70" or with the specific code for the appropriate specialty, e.g., "30" for a radiology clinic. If the process to completion date on the HCSR on or after April 30, 1999, the provider major specialty code "70" the major specialty of the provider in the clinic who provided the services must be reported. This is required information on the TED record

     Payment Error: None.

PROVIDER PARTICIPATION INDICATOR (08C on institutional records and 12I on non-institutional records). This is a 1 position alpha character on both institutional and non-institutional TED Records that indicates whether or not the provider accepted assignment of benefits for services rendered. On the UB-92 claim form, this information can be found in Form Locator 53. The provider participation agreement is in block 27 of the HCFA Claim Form 1500 and block 32 of the DD Claim Form 2520 (this form is only used for services rendered in foreign countries). All network providers must participate under the terms of their agreement with the contractor. A non-network provider agrees to participate if the participating block is checked "yes" and the provider signs the claim. If intent to participate is questionable and the non-network provider is known to routinely participate, the contractor shall contact the provider to determine intent. All claims processed under the DRG reimbursement methodology must be participating.

In all cases where the contractor has documented knowledge of payment by the beneficiary or other party, the payment shall be appropriately disbursed, including, when necessary, splitting payment. If the non-network provider is clearly not participating or the intent cannot be determined, the beneficiary is to be paid. This is required information.

     Payment Error: A participating claim paid on a nonparticipating basis or a non-participating claim paid on a participating basis my result in a payment error.

PROVIDER STATE OR COUNTRY CODE (04C on institutional records and 09I on non-institutional records). This is a 3 position alphanumeric field on both institutional and non-institutional TED Records which is used to identify the

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state or foreign country in which the care was received. State code must be left justified and blank fill to right.

PROVIDER SUB-IDENTIFIER (02C on institutional records and 07I on non-institutional records). This is a 4 position alphanumeric field on both institutional and non-institutional TED Records which is the identification number that uniquely identifies multiple providers using the same Taxpayer Identification Number (TIN).   Refer to provider filing instructions. Assigned as per TRICARE instructions. Must be zero-filled if there are no multiple providers within the TIN. See Provider Sub-Identifier (Locator 3-010) in the Provider Record Data section of the TRICARE Systems Manual, Chapter 2, Section 2.10, for more information.

     Payment Errors: A payment error may exist if the Sub-Identifier is for the wrong provider and affects the determination of the allowable amount. For example, the care provided in a clinic is one-hour of psychotherapy for which the contractor used the Sub-Identifier for a Psychiatrist when the services were actually rendered by a Clinical Social Worker.

PROVIDER TAXPAYER NUMBER: (01C on institutional records and 06I on non-institutional records). This is a 9 position alphanumeric field on both institutional and non-institutional TED records which is the IRS Taxpayer Identification Number (TIN) assigned to the institution/provider supplying the care.   For institutions, the TIN must be a 9-digit Employer Identification Number (EIN). For individual providers, a 9-digit EIN or SSN must be used, if available. If not available, report the contractor-assigned number. (See Provider File data element Provider Taxpayer Number 3-005 in the provider record for instructions). Report all nines for transportation services under Program for Persons with Disabilities and for Drug Program when the services are from a non-participating pharmacy. This is required information

     Payment Error: Payment made to the wrong provider due to incorrect entry and payment to a provider when a "dummy" number is coded may result in a payment error.

PROVIDER ZIP CODE (05C on instituional records and 10I on non-institutional records).) This is a 9 position alphanumeric field on both institutional and non-institutional TED Records which is the provider's business office where the care is usually provided. The entry must be a valid 5 or 9 digit zip code. If only 5 digits, left justify and blank fill to right. If a foreign country, must be 3 character foreign country code left justify and blank fill to right. This is required information.

     Payment Error: Incorrect amount allowed may occur if zip code for location of care is incorrect.

RECORD TYPE INDICATOR (09a on institutional records and 14I on non-institutional records). This is 1 position alphanumeric character on both institutional and non-institutional TED Records which indicates the type of record. This is required information on the TED Record. Refer to TRICARE Systems Manual, Chapter 2, Section 1.2, paragraph 1.0 for additional information.

     Payment Error: Institutional claims processed as non-institutional or non-institutional claims processed as institutional may result in a payment error.

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REVENUE CODE (01H) This is a 4 position alphanumeric field on the institutional TED Record which identifies revenue categories associated with the type of service rendered. Like revenue codes should be summarized to one occurrence for reporting on the TED Record. Room and board revenue codes can be summarized if the code and rate are the same. Denied revenue codes must be reported as separate occurrences within the TED Record. On the UB-92 claim form, the Revenue Code and Revenue Description are found in Form Locators 42 and 43. This is required information. Use UB-92 revenue codes.

Payment Error: An incorrect revenue code which allows payment for a non-covered service/supply or a higher or lower room rate allowance may result in a payment error.

SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODES (12E through 16E) There are two data element fields each containing 5 alphanumeric characters on the institutional record which identify the procedures, other than the principal procedure, performed during the period covered by the TED Record. Refer to International Classification of Diseases - Clinical Modification, Edition 9, Volume 3, for valid ICD-9-CM Operation/Non-surgical codes. The most detailed procedures must be coded. Must be left justified and blank filled. On the UB-92 claim form, this information is found in Form Locators 81.

Payment Error: The amount paid on claims subject to DRG reimbursement may be affected by secondary procedure codes if their presence (or absence) causes an incorrect DRG assignment.

SECONDARY TREATMENT DIAGNOSIS (02F through 05F on non-institutional records and 03E through 10E on institutional records). There are four data element fields on the non-institutional TED Record and eight data element fields on the institutional TED Record. Both the non-institutional and institutional records contain 6 alphanumeric characters which correspond to the additional conditions that coexist at the time of admission or during the treatment encounter. Use the most current diagnosis edition (ICD-9-CM) as directed by TMA. Code must be left justified and blank filled. The most detailed procedure must be coded. On the UB-92 form, this information can be found in Form Locators 68. These fields are required if available.

Payment Error: The amount paid on claims subject to DRG reimbursement may be affected by secondary diagnosis codes if their presence (or absence) causes an incorrect DRG assignment.

SEQUENCE NUMBER (03A) This is a 7 position alphanumeric field on both institutional and non-institutional TED Records which is a sequential number assigned by the contractor to identify the individual TED Record. Along with the Filing Date and Filing State/Country Code, the sequence number comprises the Internal Control Number (ICN). Once assigned, the sequence number cannot be re-used with the same Filing Date and Filing State/Country Code. This is required information on the TED record.

Payment Error: None.

SOURCE OF ADMISSION (03D) This is a 1 position alphanumeric field on the institutional TED Record which indicates the admission referral source. On the UB-92 claim form, this information is found in Form Locator 20. The source of admission codes include a special code structure to be used.

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Reference: TRICARE Systems Manual, Chapter 2, Section 2.8 (Q-S). This is required information.

    <u>Payment Error:</u>   None.

<u>SPECIAL PROCESSING CODE</u> (08a on institutional records and 01I on non-institutional records). This is a 2 position alphanumeric field on both institutional and non-institutional TED Record which indicates care that requires special processing. Four occurrences are allowed per line item for non-institutional records. This is a required field if TED Record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Codes cannot be duplicated. Reference: ADP Manual, Chapter 2, Section 2.8 (Q-S) for a complete list of codes.

    <u>Payment Error:</u>   The following may result in payment errors:

    1.   Payment made to a civilian provider for a bone marrow transplant without authorization.
    2.   Payment made for a liver transplant which is specified as contradiction in the policy manual.

<u>SERVICE BRANCH CLASSIFICATION CODE (Sponsor)</u> (08B) This is a 1 position alphanumeric field on both institutional and non-institutional TED Records which represents the branch classification with which the sponsor is affiliated as downloaded/verified through DEERS. This information is to be downloaded by the contractor from DEERS and if not available the service branch from the claim or treatment encounter may be used. Use 'X' for CHAMPVA claims. This is a required field.

    <u>Payment Error:</u>   None.

<u>TOTAL CHARGE BY REVENUE CODE</u> (03H) This is an 9 position signed numeric field on the institutional TED Record which includes 2 decimal places. This is the amount billed by revenue code. Must be equal to or less than 999,999.99 unless Revenue Code 001 which must be equal to or less than 9,999,999.99. On the UB-92 claim form, this information is found in Form Locator 47. This field is required information.

    <u>Payment Error:</u>   An incorrect amount reported on the TED Record may result in a payment error.

<u>TOTAL OCCURRENCE/LINE ITEM COUNT</u>   (20A) This is a 3 position field on both the institutional and non-institutional TED record. For institutional record this field represents a set of revenue codes and related data elements that occur on the record. For non-institutional records this field represents the number of sets of procedure codes and related utilization data elements that occur on the record. There can be up to 999 occurrences for institutional records and up to 99 occurrences for non-institutional records. The institutional record must be greater than 0 and not more than 999. The non-institutional record must be greater than 0 and not more than 99. This is a 3 digit field to allow for growth. However, the TED value for this field cannot exceed 99.

    <u>Payment Error:</u>   None.

<u>TYPE OF ADMISSION</u> (02D) This is a 1 position alphanumeric character on the institutional TED Record which indicates the type of admission. Use of code

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4 necessitates the use of special Source of Admission codes (A through D) and must not be used for the mother's charges. On the UB-92 claim form, this information can be found in Form Locator 19. This is required information which must be developed if not received in the treatment encounter data.

Payment Error: An erroneous medical emergency determination for a patient residing within a catchment area may result in a payment error.

TYPE OF INSTITUTION   (06C) This is a 2 position alphanumeric field on the institutional TED Record which describes the type of institution for institutional providers. This data serves to identify the capacity of the facility for the specific care entered on each institutional record. On the UB-92 claim form, the type of institution can be found in Form Locator 4 which is a 3 digit field. The first digit of that entry is the type of facility. Refer to the National Uniform Billing Data Element Specifications manual for the specific codes. For UB-92 claims, the auditor should verify that the TRICARE assigned Type of Institution code is the same as that reported by the provider facility. This is required information.

Payment Error: Payment made for care in a facility requiring TMA approval when such approval does not exist may result in a payment error.

TYPE OF SERVICE (25I) This is a 2 position alphanumeric field on the non-institutional TED Record which indicates the type of service provided. This field actually has two positions to code. Refer to TRICARE Systems Manual, Chapter 2, Section 2.9 (T-Z) for a list of first and second position codes. This is required information.

Payment Error: The following may result in payment errors:

1.   Erroneous first position code results in an incorrect application of the coinsurance/copayment.

2.   Erroneous second position code results in the application of the incorrect reimbursement methodology, e.g., anesthesia services reimbursed as assistant surgeon charges.

TYPE OF SUBMISSION (04A) This is a 1 position alphanumeric field on both institutional and non-institutional TED Records which indicates the TED record submission type. There are four types of TED Records which are:

        Initial Submission
        Adjustment Submission
        Resubmission
        Complete Denial

Within the initial and adjustment submissions are various Type of Submission codes which indicate, for example, an initial TED Record submission, an adjustment to a prior TED record, or and adjustment to non-TED data, etc. Non-TED record codes 'B' and 'E' are to be used when reporting cancellation or adjustment for a claim that was initially processed using HCSR Record format. Codes 'B' and 'E' are not valid if Beginning Date of Care is on or after 10/01/2007. This is required information.

Payment Error: Claims denied or paid in error may be payment errors.

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UNITS OF SERVICE BY REVENUE CODE (02H) This is a 7 position signed numeric field on the institutional record which is the number of services rendered or number of days, by revenue category. Must be equal to or less than 9999. On the UB-92 claim form, this information is found in Form Locator 46. This is required information.

      Payment Error: None.

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CHAPTER 5 - ASSESSMENT OF TED RECORD CONTRACTOR ERRORS

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CHAPTER 5 - ASSESSMENT OF TED RECORD CONTRACTOR ERRORS

A.   Introduction. This chapter discusses how TRICARE Encounter Data (TED) Record occurrence errors, payment errors, and procedural documentation errors are determined during the claims audit. Related guidelines are in Chapter 3, "Auditing Special Claim Conditions," and Chapter 4, "Auditing TED Record Data Elements." Exhibit 1 at the end of this chapter lists the codes used to indicate errors.

B.   TRICARE Encounter Data (TED) Record Occurrence Errors. All TED Record occurrence errors, including errors in financial fields, are counted and the error rate is expressed as a percentage of the total number of data fields in the TED Record.

     1.   General. Occurrence errors are assessed for an incorrect entry in any data field of any TED Record type. Any error, including errors in financial fields, will be counted as occurrence errors. For audit purposes, the occurrence errors on the TED Record have been assigned special codes which are grouped under the ten categories "A" through "J" below. There are two general types of occurrence errors - those which are associated with specific data fields (error categories "A" through "I,') and those which are not (error category "J"). All occurrence errors assessed are entered in the automated TED Record audit system utilizing the code designating the particular error.

     2.   Errors Specific to Data Fields. (See Chapter 4 for the names of the specific data fields in the "A" through "I" categories and detailed instructions for auditing these fields.)

"A"	Category Errors	Incorrect Claim Information
"B"	Category Errors	Incorrect Patient/Sponsor Information
"C"	Category Errors	Incorrect Provider Information
"D"	Category Errors	Incorrect Admission/Discharge Information (Institutional TED Record only)
"E"	Category Errors	Incorrect Diagnosis/Treatment Information (Institutional TED Record only)
"F"	Category Errors	Incorrect Diagnosis Information (Non-institutional TED Record only)
"G"	Category Errors	Incorrect Financial Information
"H"	Category Errors	Incorrect Institutional Revenue Data
"I"	Category Errors	Incorrect Non-institutional Claims/Provider/ Utilization Information

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3.   <u>Errors not Specific to Data Fields</u> "J" Category Errors for Incorrect/ Unsupported
Record Errors are assessed in instances when the contractor is not in compliance with the requirements in the TRICARE Systems Manual for reporting entire TED Records or records within the TED Record, when the contractor does not submit entire claims for audit, or when the documentation submitted is illegible or incomplete rendering it unauditable. In these situations, occurrence errors are assessed for the error condition(s) attributable to the TED Record as a whole rather than to specific data fields. The following pertains to determining errors for these special conditions which are not associated with a particular data field.

a.   <u>"J" Category Error Conditions and Number of Errors Assessed</u>

AUDIT CODE	RECORD	ERROR LOC	DESCRIPTION
01J	N	Detail	UNLIKE PROCEDURE COMBINED *7 errors for each erroneous utilization data set.
02J	I	Detail	UNLIKE REVENUE CODES COMBINED **5 errors for each erroneous revenue code set
03J	I – N	Detail	SERVICES SHOULD BE COMBINED 1 error for each additional revenue code/ utilization data set
04J	N	Common	MISSING NON-INSTITUTIONAL DATA SET *7 errors for each missing utilization data set
05J	N	Detail	EXTRA NON-INSTITUTIONAL UTILIZATION DATA SET *7 errors for each extra utilization data set
06J	I	Common	MISSING INSTITUTIONAL REVENUE CODE SET **5 errors for each missing revenue code set
07J	I	Detail	EXTRA INSTITUTIONAL REVENUE CODE SET **5 errors for each extra revenue code set
08J	I – N	Common	INCORRECT RECORD TYPE 5 errors
09J	I – N	Detail	SEPARATE TED RECORD REQUIRED 3 errors
10J	I – N	Common	CLAIM NOT PROVIDED FOR AUDIT 1 error plus 1 error for each revenue code/ utilization data set in the TED Record
11J	I – N	Common	CLAIM NOT AUDITABLE 1 error plus 1 error for each revenue code/ utilization data set in the TED Record

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AUDIT CODE	RECORD	ERROR LOC	DESCRIPTION
12J	I – N	Common	UNSUPPORTED TED RECORD TRANSACTION 1 error plus 1 error for each revenue code/ utilization data set in the TED Record

* Not to exceed 21 errors for combination of OIJ, 04J and 05J error types.

** Not to exceed 15 errors for combination of 02J, 06J and 07J error types.

N = Non-Institutional TED Record

I = Institutional TED Record

Detail error location means the error pertains to a specific revenue code or utilization data set in the TED Record.

Common error location means the error pertains to the TED Record as a whole and not to any specific revenue code or utilization data set in the TED Record.

    b.   Auditing "J" Category Errors

     01J UNLIKE SERVICES COMBINED (Non-Institutional) TRICARE Operations Manual, Chapter 6. Section 7.0., states that combining charges for the same procedures having the same billed charges under the contractor's "financially underwritten" operation, for TRICARE Encounter Data Records, is optional with the contractor if the same action is taken with all. When unlike services are combined, the auditor will assess an 0lJ error for each utilization data occurrence set within the TED Record containing incorrectly combined services up to a maximum of three OlJ errors per claim (or any combination of 01J, 04J and 05J). No other occurrence errors will be assessed against a line item for which the 0lJ error was charged.

The automated TED Record audit system will assess seven occurrence errors for each 0lJ error up to a maximum of 21 errors or an aggregate total of three (3) 01J, 04J or 05J errors for a maximum of 21 errors per claim.

     02J UNLIKE REVENUE CODES COMBINED (Institutional). TRICARE Systems Manual, Chapter 2, Section 5.4, Locator 1-385 provides for summarizing like revenue codes on the TED Record. Room and board revenue codes can be summarized if the code and rate are the same. Denied revenue codes must be reported on separate occurrence(s) within the TED Record. The auditor will assess an 02J error for each revenue data occurrence set within the TED Record containing incorrectly summarized revenue codes up to a maximum of three 0lJ errors per claim (not to exceed 15 errors for combination of 02J, 06J and 07J error types). No other occurrence errors will be assessed against a line item for which the 02J error was charged. The automated TED Record audit system will assess five occurrence errors for each 02J error up to a maximum of 15 errors or an aggregate total of three (3) 02J, 06J or 07J errors for a maximum of 15 errors per claim.

     03J SERVICES SHOULD BE COMBINED (Institutional and Non-Institutional). This 03J error condition is the opposite of OlJ (Unlike Services Combined)

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described above except that only one error is assessed for each additional revenue data occurrence set or utilization data occurrence set within the TED Record. This error also applies when the contractor "splits" a single service into more than one line item, e.g., a single charge for monthly rental of Durable Medical Equipment. All data fields on the revenue data occurrence set or utilization data occurrence set within the TED Record with this error condition should be audited for other error conditions.

    04J MISSING NON-INSTITUTIONAL UTILIZATION DATA SET (Non-Institutional). Certain formatting errors result in utilization data occurrence sets not being reported on the TED Record as they would have been if the transaction was correctly coded by the contractor. For example, when a utilization data occurrence sets is not reported because the contractor failed to process all the billings with the claim. When missing line items are identified, the auditor will assess an 04J error for each missing utilization data occurrence set within the TED Record up to a maximum of three errors per claim.

The automated TED Record audit system will assess seven occurrence errors for each 04J error up to a maximum of 21 errors or an aggregate total of three 01J, 04J or 05J errors for a maximum of 21 errors per claim.

    05J EXTRA NON-INSTITUTIONAL UTILIZATION DATA SET (Non-Institutional). Extra records may occur on the TED Record due to various reasons. One common example is when a utilization data occurrence set is coded for services not being claimed. When extra line items are present, the auditor will assess an 05J error for each extra utilization data occurrence set within the TED Record up to a maximum of three 05J errors per claim.

The automated TED Record audit system will assess seven occurrence errors for each 05J error up to a maximum of 21 errors or an aggregate total of three 01J, 04J or 05J errors for a maximum of 21 errors per claim.

    06J MISSING INSTITUTIONAL REVENUE CODE SET (Institutional). Certain formatting errors result in revenue data occurrence sets not being reported on the TED Record as they would have if the transaction was correctly coded by the contractor. For example, when a revenue data occurrence set is not reported because the contractor failed to process all the billings with the claim. When missing line items are identified, the auditor will assess an 06J error for each missing revenue data occurrence set within the TED Record up to a maximum of three errors per claim.

The automated TED Record audit system will assess five occurrence errors for each 06J error up to a maximum of 15 errors or an aggregate total of three 02J. 04J or 06J errors for a maximum of 15 errors per claim.

    07J EXTRA INSTITUTIONAL REVENUE CODE SET (Institutional). Extra records may occur on the TED Record due to various reasons. One common example is when a revenue data occurrence set is coded for services not being claimed. When extra line items are present, the auditor will assess an 07J error for each extra revenue data occurrence set within the TED Record up to a maximum of three 07J errors per claim.

The automated TED Record audit system will assess five occurrence errors for each 07J error up to a maximum of 15 errors or an aggregate total of three 02J, 04J or 07J errors for a maximum of 15 errors per claim.

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08J INCORRECT RECORD TYPE (Institutional and Non-institutional). Record type code 1 is to be used for institutional claims and record type code 2 is to be used for non-institutional claims. When other than the above two codes are used or when the record type on the TED Record is coded incorrectly for the services rendered an 08J error is assessed. The automated TED Record audit system will assess five errors for each record type assessed an 08J error.

09J SEPARATE TED RECORDS REQUIRED (Institutional and Non-Institutional). The ADP Manual, Chapter 1, Section 3. 1.0 and 2.0 requires that the TED Record consist of either an institutional or non-institutional record and lists the type of treatment encounter data that must be reported on separate TED Records. If treatment encounter data does not meet the conditions listed in the ADP Manual an 09J error is assessed. The automated TED Record audit system will assess three errors when a separate TED Record is required.

10J CLAIM NOT PROVIDED FOR AUDIT(Institutional and Non-institutional). One 10J error is to be assessed for each claim selected for the audit sample, but not provided by the contractor. When a 10J error is assessed the automated TED Record audit system will assess one error plus one additional error for each revenue data occurrence set or utilization data occurrence set on the TED Record. No other occurrence errors will be assessed.

1IJ CLAIM NOT AUDITABLE (Institutional and Non-Institutional). One 11J error is to be assessed for in auditable claims that result from illegible copies of claims or attendant documentation, e.g., itemized bills, which are critical for the claim to be properly audited. When an 11J error is assessed the automated TED Record audit system will assess one error plus one additional error for each revenue data occurrence set or utilization data occurrence set on the TED Record. No other occurrence errors will be assessed.

12J UNSUPPORTED TED RECORD TRANSACTION (Institutional and Non-Institutional.). One 12J error for unsupported TED Record is to be assessed only when documentation submitted by the contractor for the audit does not indicate (does not support) that a claim against the government exists or that a TED Record is required. Examples are a TED Record created solely for the contractor's internal accounting purposes and an "adjustment" processed when no determination or an incorrect determination has been made by the contractor that the TED Record as originally submitted requires correction. Only one 12J error is to be assessed per claim. When a 12J error is assessed the automated TED Record audit system will assess one error plus one additional error for each revenue data occurrence set or utilization data occurrence set on the TED Record. No other occurrence errors are to be charged on a record when a 12J error is charged.

Claims denied for one reason which subsequently is resolved, e.g., ineligibility or requested information not received, are to be reprocessed with a new claim number and may be denied again for another reason. These situations are legitimate transactions and are not to be considered as 12J errors.

C. Payment Errors: The following types of payment errors and the codes for each are in effect for the contractors processing under the TED Record system. All apply to both Institutional and Non-Institutional claims.

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(1)   There are two categories of payment errors: (1) a payment error which cannot be removed by contractor post payment processing actions and; (2) a payment error which can be removed by contractor post payment processing actions.   Payment errors which can be removed by contractor post payment actions will also be assessed a process error at audit.   If contractor post payment actions substantiate the initial processing decision, the payment error will be removed but the process error will remain. If the initial processing action is not substantiated, both the payment and the process error will remain. Claims containing process errors will not affect contractor payment or occurrence error rates, but will be used as a performance indicator.

(2)   Payment errors are the amount of over/under payment on a claim, including but not limited to a payment in the correct amount but sent to the wrong payee, denial of a payable claim, misapplication of the deductible, payment of a non-covered service/supplies, or services/supplies for which a benefit determination cannot be made based on the information available at the time of processing.   Process errors result from: noncompliance with a required procedure or process, such as development required but not performed, medical emergency not substantiated, medical necessity/review not evident and are cited in conjunction with a payment error.   Process error determinations are based on the claim information available and those processing actions taken at the time of adjudication by the contractor.

(3)   Payment errors which may not be removed by contractor post payment actions are based only on the claim information available and those processing actions taken at the time of adjudication by the contractor. Actions and determinations occurring subsequent to the processed date of the audited claim, are not a consideration of the audit for paid claims regardless of whether resolution of a payment error results. Subsequent reprocessing of a denied claim is considered as long as the processed to completion date of the reprocessed claim is prior to the run date of the audit sample.

(4)   <u>Types of Payment Errors</u>: The following errors may be assessed. (An * indicates those payment errors which can be removed if contractor post payment actions substantiate the initial processing decision.)

*01K <u>AUTHORIZATION/PREAUTHORIZATION NEEDED</u> is assessed when the contractor paid a claim for which no authorization form is submitted when required. (Payment error may be removed by post payment actions only if PFPWD or adjunctive dental authorizations.)

*02K <u>BENEFIT DETERMINATION UNSUPPORTED</u> is assessed when the payment was made for services or supplies which require additional documentation to consider them as TRICARE benefits.

*03K <u>BILLED AMOUNT INCORRECT </u> is assessed when the contractor based payment on a billed amount other than what was being claimed.

04K <u>COST-SHARE/DEDUCTIBLE   ERROR</u> is assessed when the contractor incorrectly calculated either of these amounts for reasons not covered in any of the other "K" category errors, e.g., when the retiree cost-share is applied for services provided a dependent of an active duty sponsor.

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*05K DEVELOPMENT CLAIM DENIED PREMATURELY is assessed when a claim is denied before the time period specified in the TRICARE Operations Manual for development claims after the contractor has requested additional information in writing.

*06K DEVELOPMENT REQUIRED is assessed when the contractor processed the claim without taking action to obtain additional or correct information needed to correctly adjudicate the claim when such action is required by the TRICARE Operations Manual.

07K DUPLICATE SERVICES PAID is assessed when the beneficiary history indicates that some or all of the services on the audited claim were paid previously, or when services are denied for duplicate by the contractor but the duplicate service is not found in the patient history.

08K ELIGIBILITY DETERMINATION - PATIENT is assessed when the claim was paid or denied based on an incorrect eligibility determination for the patient.

09K ELIGIBILITY DETERMINATION - PROVIDER is assessed when the claim was paid or denied based on an incorrect determination of the provider's authorization status for providing care under TRICARE.

*10K MEDICAL EMERGENCY NOT SUBSTANTIATED is assessed when a claim was paid as an emergency (Type of Admission = 1) and the claim does not qualify to be paid as such based on the TRICARE Reimbursement Manual requirements, i.e., the diagnosis is not among those which "automatically" qualify as medical emergencies, no medical review is evident, and a Nonavailability Statement or authorization is required.

*11K MEDICAL NECESSITY NOT EVIDENT is assessed when a claim was paid without documentation of medical review when medical review is required or when documentation of medical necessity is required and not provided with the claim.

12K NONAVAILABILITY STATEMENT ERROR is assessed when payment is made for non-emergency inpatient care provided a beneficiary residing within a Military Treatment Facility's catchment area for which no Care Authorization/Non-Availability Statement (CA/NAS) or an invalid CA/NAS is submitted.

13K OHI - GOVT PAY MISCALCULATED is assessed when the contractor incorrectly determines the amount of the TRICARE payment after applying the amount of the other insurance payment.

14K OHI PAYMENT ERROR is assessed when the claim contains documentation of other health insurance payment and the contractor fails to consider this in determining the TRICARE liability.

15K PAYEE WRONG - SPONSOR/PATIENT is assessed when payment is made to the incorrect sponsor or patient.

16K PAYEE WRONG - PROVIDER is assessed when payment on participating claim was made to an incorrect provider.

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17K PARTICIPATING/NONPARTICIPATING ERROR is assessed when a claim was paid to the provider who did not indicate participation on the claim or, conversely, to a patient or sponsor when the provider indicated participation.

18K PRICING INCORRECT is assessed when the amount allowed for a correct procedure code was incorrectly determined for any service or supply on the claim and results in an incorrect reimbursement.

19K PROCEDURE CODE INCORRECT is assessed when use of an incorrect procedure
code resulted in incorrect reimbursement.

20K SIGNATURE ERROR is assessed when payment was made on a claim which does not contain the appropriate beneficiary or provider signature or does not contain beneficiary signature.

*21K TIMELY FILING ERROR is assessed when benefits for dates of service not meeting the timely filing requirement were paid without an appropriate waiver of the filing deadline, or when benefits were denied for not meeting the filing deadline when submission was timely.

22K DRG REIMBURSEMENT ERROR is assessed when an error was made by contractor in determining the reimbursement due an institution based on the DRG payment system.

23K CONTRACT JURISDICTION ERROR is assessed when benefits were paid for services or supplies rendered out of jurisdiction.

24K BENEFIT DETERMINATION WRONG is assessed when the payment was made for services or supplies which are not TRICARE benefits.

25K CLAIM NOT PROVIDED is assessed when the claim is selected for audit and not provided by the contractor.

26K CLAIM NOT AUDITABLE is assessed for in auditable claims that result from
illegible copies of claims or attendant documentation which are critical for the claim to be properly audited.

27K INCORRECT NETWORK PROVIDER/ENROLLMENT DETERMINATION is assessed when TED was processed with an incorrect network provider or an incorrect enrollment determination was made. An error exists when the provider affiliation code shows a provider paid as a network contractor or subcontractor when the provider was not under contract or vice versa. An error also exists when the enrollment status shows a beneficiary as enrolled in TRICARE Prime and contractor paid the claim as non-enrollee or vice versa.

*99K OTHER - SEE REMARKS is assessed when a payment error is detected and none of the above reasons apply. The auditor is to specify the reason for the payment error assessment in the free-form comments section of the screen when entering the audit errors in the automated HCSR Audit System.

5.   Assessing Payment Errors The TED Record audit system calculates both positive and negative payment error amounts.

CLAIMS AUDIT GUIDELINES

Therefore, when the contractor makes an overpayment on a claim that error is entered as a positive dollar amount and when the contractor makes an underpayment on a claim that error is entered as a negative dollar amount. The following rules apply when assessing payment errors:

a.   Multiple payment error reasons which are different will be coded with the appropriate "K" error reason for a single TED Record.

b.   In some cases, more than one payment error reason can apply, e.g., payment of a participating claim as nonparticipating and payment without an NAS. These are two mutually exclusive reasons, i.e., neither is dependent on the other. If only one of these conditions existed, the payment error would still exist. Each error is counted in these situations.

c.   Auditors must ensure that only mutually exclusive reasons are assessed when determining that more than one reason applies. It is possible that more than one reason will appear to be appropriate when, in fact, they are related, e.g., incorrect procedure and incorrect pricing when the incorrect pricing is actually a result of the contractors use of an incorrect procedure.

6.   <u>Amount Billed for Computation of Payment Error Rates</u> The TED Record audit system will display the amount allowed on DRG claims in the amount billed field and this field does not need to be changed except when the DRG amount allowed was incorrectly calculated by the contractor. The total amount billed will be computed by the TED Record Audit System as the total of the billed amounts on the TED Audit Detail Reports (TADRs) for a particular audit.

D.   <u>Procedural/Documentation Errors</u> These errors listed on the TED Record Audit Detail Report as category "L" errors are neither occurrence errors nor payment errors and are not used to calculate the occurrence error or payment error rates. "L" errors are used to document the contractor's procedural errors and documentation problems which impact the audit process or indicate a situation of contractual noncompliance which is identifiable during the audit and requires follow-up corrective action by the appropriate Contracting Officer's Representative.

<u>0Ll AUDIT DOCUMENTATION INCOMPLETE</u> is assessed when certain documentation contractually required for the audit is not initially submitted with the claim for audit. This error differs from the 10J error, "Claim Not Provided", and the 11J error, "Claim Not Auditable," in that it does not prevent the auditor from completing the audit of the particular claim.

<u>02L AUDIT DOCUMENTATION ILLEGIBLE</u> is assessed when the contractor submits poor copies of claims or claim documentation, the legibility of which is difficult but does not impede the audit. This error differs from the 11J error, "Claim Not Auditable," in that auditing of the claim can be completed.

<u>03L DOCUMENTATION SUBMITTED LATE</u> is assessed when the contractor submits required claim documentation after completion of the audit, e.g., with the rebuttal.

<u>04L EOB INCORRECT</u> is assessed when information on the Explanation of Benefits does not meet the TRICARE Operations Manual requirements, e.g. EOBs

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addressed to minors or deceased individuals or EOBs containing incorrect denial messages.

05L NAS QUESTIONABLE is assessed when the contractor processed a claim based on an incorrectly completed or apparently invalid CA/NAS without verifying its validity but which did not contribute to a payment error.

06L ERROR IN CLAIM HISTORY is assessed when the beneficiary claims history contains incorrect data, regardless of whether it pertains to the claim being audited.

07L RESERVED

08L ERRONEOUS CLAIM SPLIT is assessed when the contractor does not follow the Operations Manual limitations for creating more than one claim out of a single claim. When the contractor fails to process all services submitted on the claim being audited, the auditor is to check the beneficiary history to determine if the contractor processed these services as another claim and determine if this split is authorized by the TRICARE Operations Manual.

09L ERRONEOUS TED RECORD SPLIT is assessed when the treatment encounter data on the TED Record is not reported in accordance with the instructions in the TRICARE Systems Manual.

10L ADJUSTMENT - NO AUTHORIZING OFFICIAL is assessed when the contractor documentation supporting an adjustment does not contain the name of the authorizing person as required by its contract.

11L CONTRACT JURISDICTION ERROR is assessed when the contractor processed a claim out of their jurisdiction.

E.   Process Errors: These errors are assessed for noncompliance of a required procedure/process. These errors are neither occurrence errors nor payment errors and are not used to calculate the occurrence error or payment error rate.

01P Authorization/Pre-authorization needed (PFPWD and adjunctive dental authorizations)

02P Unsupported Benefit Determinations

05P Development Claim Denied Prematurely

06P Development Required

10P Medical Emergency Not Substantiated

11P Medical Necessity/Review Not Evident

21P Timely Filing Error

23P Contract Jurisdiction Error

99P Other

CLAIMS AUDIT GUIDELINES

EXHIBIT 1

AUDIT CODE	TADR ABBREVIATION	DATA FIELD NAME
TED AUDIT ERROR CATEGORIES		
A. CLAIM INFORMATION		
01A	FIL DT	Filing Date
02A	FIL ST	Filing State/Country
03A	SEQ NO	Sequence Number
04A	SUBMISN	Type Of Submission
05A	ADJ ID	Date Adjustment Identified
06A	PTC DT	Date TED Record Processed To Completion
09A	SP PROC CD	Special Processing Code
10A	PR RATE CD	Pricing Rate Code
11A	CA/NAS EXCEP	NAS Exception Reason
12A	CA/NAS #	Care Authorization/ Nonavailability Statement Number
07A	OVERRIDE	Override Code
28A	OCCURRENCE COUNT	Total Occurrence Line Item Count
14A	REC TYPE IND	Record Type Indicator
13A	CA/NAS RSN ISS CD	CA/NAS Reason for Issue Code
08A	CLM FORM TYP/EMC IND	Claim Form Type/EMC Indicator
B. PATIENT/SPONSOR INFORMATION		
01B	PERS NAME	Person Name (Patient)
02B	PERS ID PT	Person Identifier (Patient)
03B	PERS DOB	Person Birth Calendar Date (Patient)
04B	PERS SEX	Person Sex (Patient)

CLAIMS AUDIT GUIDELINES

TED AUDIT ERROR CATEGORIES		
AUDIT CODE	**TADR ABBREVIATION**	**DATA FIELD NAME**
05B	PT ZIP	Patient Zip Code
06B	PERS ID SP	Person Identifier (Sponsor)
07B	PAY GD SP	Pay Grade (Sponsor)
08B	SP BOS	Service Branch Classification Code (Sponsor)
09B	HCC MBR CD	HCC Member Category Code
10B	HCC RELAT CD	HCC Member Relationship Code
11B	ENRL/HLTH PLAN CD	Enrollment/Health Plan Code
C. PROVIDER INFORMATION		
01C	TAX ID	Provider Taxpayer Number
02C	SUB ID	Provider Sub-Identifier
03C	NTWK IND	Provider Network Status Indicator
04C	ST/CNTRY	Provider State Or Country Code
05C	ZIP	Provider Zip Code
06C	INST	Type Of Institution
07C	PROV SPEC	Provider Specialty
08C	PART ID	Provider Participation Indicator
D. ADMISSION/DISCHARGE INFORMATION		
01D	ADM DATE	Admission Date
02D	ADM TYPE	Type Of Admission
03D	ADM SOURCE	Source Of Admission
04D	PTNT STAT	Patient Status
05D	BGN DOC	Begin Date Of Care

CLAIMS AUDIT GUIDELINES

TED AUDIT ERROR CATEGORIES		
AUDIT CODE	**TADR ABBREVIATION**	**DATA FIELD NAME**
06D	END DOC	End Date Of Care
07D	FREQ	Frequency Code
08D	COVD DAYS	Covered Days

E.   INSTITUTIONAL DIAGNOSIS/TREATMENT INFORMATION

01E	ADM DX	Admission Diagnosis
02E	PRN DX	Principal Treatment Diagnosis
03E	SEC DX-1	Secondary Treatment Diagnosis-1
04E	SEC DX-2	Secondary Treatment Diagnosis-2
05E	SEC DX-3	Secondary Treatment Diagnosis-3
06E	SEC DX-4	Secondary Treatment Diagnosis-4
07E	SEC DX-5	Secondary Treatment Diagnosis-5
08E	SEC DX-6	Secondary Treatment Diagnosis-6
09E	SEC DX-7	Secondary Treatment Diagnosis-7
10E	SEC DX-8	Secondary Treatment Diagnosis-8
11E	PRN OP PROC	Principal Operation/Nonsurgical Procedure Code
12E	SEC PROC-1	Secondary Operation/Nonsurgical Procedure Code-1
13E	SEC PROC-2	Secondary Operation/Nonsurgical Procedure Code-2
14E	SEC PROC-3	Secondary Operation/Nonsurgical Procedure Code-3
15E	SEC PROC-4	Secondary Operation/Nonsurgical Procedure Code-4
16E	SEC PROC-5	Secondary Operation/Nonsurgical Procedure Code-5
17E	DRG NUMBER	DRG Number

CLAIMS AUDIT GUIDELINES

TED AUDIT ERROR CATEGORIES		
AUDIT CODE	**TADR ABBREVIATION**	**DATA FIELD NAME**
F. NONINSTITUTIONAL DIAGNOSIS INFORMATION		
01F	PRIN DX	Principal Treatment Diagnosis
02F	SEC DX-1	Secondary Treatment Diagnosis-1
03F	SEC DX-2	Secondary Treatment Diagnosis-2
04F	SEC DX-3	Secondary Treatment Diagnosis-3
05F	SEC DX-4	Secondary Treatment Diagnosis-4
G. FINANCIAL INFORMATION		
01G	AMT BILL TOT	Amount Billed (Total)
02G	AMT ALLOW TOT	Amount Allowed (Total)
03G	AMT PD OHI	Amount Paid by Other Health Insurance
04G	PNT COST SHARE	Amount Patient Cost-Share
05G	AMT PAID TOT	Amount Paid By Government Contractor (Total)
H. INSTITUTIONAL REVENUE DATA		
01H	REVENUE CODE	Revenue Code
02H	UNITS OF SERVICE	Units Of Service By Revenue Code
03H	TOTAL CHARGE	Total Charge By Revenue Code
04H	ADJ/DENIAL CODE	Adjustment/Denial Reason Code
05H	OCC LN ITEM	Total Occurrence Line Item Counter
I. NON-INSTITUTIONAL CLAIMS INFORMATION		
01I	SP PROC CD	Special Processing Code
02I	CA/NAS EXCEP	CA/NAS Exception Reason

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TED AUDIT ERROR CATEGORIES		
AUDIT CODE	**TADR ABBREVIATION**	**DATA FIELD NAME**
03I	CA/NAS #	CA/NAS Number
04I	CA/NAS RSN ISS CD	CA/NAS Reason for Issue Code
I. NON-INSTITUTIONAL PROVIDER INFORMATION		
06I	TAX ID	Provider Taxpayer Number
07I	SUB ID	Provider Sub-Identifier
08I	NTWK IND	Provider Network Status Indicator
09I	ST/CNTRY	Provider State Or Country Code
10I	ZIP	Provider Zip Code
11I	PROV SPEC	Provider Specialty
12I	PART ID	Provider Participation Indicator
I. NON-INSTITUTIONAL UTILIZATION DATA		
13I	LN ITM #	Line Item Number
14I	PROC CODE	Procedure Code
15I	NBR SERV	Number of Services
16I	AMNT BILLED PROC	Amount Billed by Procedure Code
17I	AMOUNT ALLOWD	Amount Allowed by Procedure Code
18I	PTN CST-SHR	Patient Cost-Share by Procedure
19I	APPL DED	Amount Applied Toward Deductible
20I	AMNT PD PROC	Amount Paid Government Contractor By Procedure Code
21I	PRICE RATE CODE	Pricing Rate Code
22I	BGN DT CARE	Begin Date Of Care by Procedure Code
23I	END DT CARE	End Date Of Care by Procedure Code

CLAIMS AUDIT GUIDELINES

TED AUDIT ERROR CATEGORIES		
AUDIT CODE	**TADR ABBREVIATION**	**DATA FIELD NAME**
24I	PLA SRV	Place Of Service
25I	TYPE SRV	Type Of Service
26I	ADJ/DNL REASON	Adjustment/Denial Reason Code
27I	CPT-4 MOD	CPT-4 Modifier

J.   INCORRECT/UNSUPPORTED RECORD ERRORS   (No specific data field applies to these codes.)

  01J   Unlike Procedures Combined

  02J   Unlike Revenue Codes Combined

  03J   Services Should Be Combined

  04J   Missing Non-institutional Utilization Data Set

  05J   Extra Non-institutional Utilization Data Set

  06J   Missing Institutional Revenue Code Set

  07J   Extra Institutional Revenue Code Set

  08J   Incorrect Record Type

  09J   Separate TED Record Required

  10J   Claim Not Provided For Audit

  11J   Claim Not Auditable

  12J   Unsupported TED Record Transaction

  K.   INCORRECT PAYMENT ERRORS   (No specific data field applies to these codes.)

  01K   Authorization/Preauthorization Needed

  02K   Benefit Determination Unsupported

  03K   Billed Amount Incorrect

  04K   Cost-Share/Deductible Error

  05K   Development claim denied prematurely

  06K   Development Required

CLAIMS AUDIT GUIDELINES

07K   Duplicate Services Paid

08K   Eligibility Determination - Patient

09K   Eligibility Determination - Provider

10K   Medical Emergency Not Substantiated

11K   Medical Necessity Not Evident

12K   CA/NAS Error

13K   OHI - Government Pay Miscalculated

14K   OHI Payment Omitted

15K   Payee Wrong - Sponsor/Patient

16K   Payee Wrong - Provider

17K   Participating/Nonparticipating Error

18K   Pricing Incorrect

19K   Procedure Code Incorrect

20K   Signature Error

21K   Timely Filing Error

22K   DRG Reimbursement Error

23K   Contract Jurisdiction Error

24K   Benefit Determination Wrong

25K   Claim Not Provided

26K   Claim Not Auditable

27K   Incorrect At Risk System

99K   Other - See Remarks

L.   DOCUMENTATION/INCORRECT PROCEDURE ERRORS   (No specific data field applies to these codes).

01L   Audit Documentation Incomplete

02L   Audit Documentation Illegible

03L   Documentation Submitted Late

04L   EOB Incorrect

05L   CA/NAS Questionable

06L   Error In Claim History

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07L   Reserved

08L   Erroneous Claim Split

09L   Erroneous TED Record Split

10L   Adjustment - No Authorizing Official

11L   Contract Jurisdiction Error

M.   <u>PROCESS ERRORS</u>

01P   Authorization/Pre-Authorization Needed (PFTH and Adjunctive
        Dental Authorizations)

02P   Unsupported Benefit Determination

05P   Development Claim Denied Prematurely

06P   Development Required

10P   Medical Emergency Not Substantiated

11P   Medical Necessity/Review Not Evident

21P   Timely Filing Error

23P   Contract Jurisdiction Error

99P   OTHER